
10 Common Medicolegal Questions on HIV Infection

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As the HIV pandemic continues, physicians will increasingly face both medical and legal questions when caring for these patients. Using a question and answer format, we provide in this paper, a guide to physicians in Hawaii on the medicolegal issues surrounding HIV infection.

Given the ongoing Human Immunodeficiency Virus (HIV) pandemic, practicing physicians have no choice but to confront both the medical and legal issues raised by this infection. A specialized body of law governs HIV infection and acquired immunodeficiency syndrome (AIDS); promulgated to protect patients from discrimination, breach of confidentiality, and invasion of privacy. Legal protection also assures HIV-positive health care providers that their rights will not be unduly abridged.

In November of 1994, the Centers For Disease Control (CDC) estimated that 17 million persons worldwide have already been infected with HIV and that approximately 6,000 more contract the disease daily. The CDC further estimated that by the year 2000, approximately 10 million children will have been orphaned because their parents have died of AIDS.¹ Many physicians worry that they will be infected by a patient, despite the low 0.2-0.3% risk of contraction following a needle stick from an HIV-positive patient. As of 1991, forty health care workers were thought to have acquired HIV from patients.²

In actuality, the physician is far more likely to contract hepatitis B. The estimated risk of this viral infection following a needle stick is in the range of 6-30%, and every year an estimated 12,000 health care workers become infected with hepatitis B, resulting annually in 250 deaths.³

Many physicians still avoid HIV-positive patients. Some may truly feel that they are not competent in this area, while others may use this rationale as an excuse for their fears and biases. Many HIV patients are IV drug abusers or homosexuals, but their need for professional medical attention and empathy is the same as that of the population at large.

The following discussion treats HIV-related medicolegal issues in a question-and-answer format. These issues can be broken down into three categories: those of physician choice, patient consent, and confidentiality. *Choice* questions ask whether or when a physician may refuse to treat an HIV patient. *Consent* issues include HIV testing without permission and whether the HIV-positive physician needs to disclose his own infection to patients so they can "consent" to being treated by the infected physician. *Confidentiality* issues address the limits of disclosure to other parties such as other physicians or health care institutions, schools, employers, health insurers, spouses, and other patient contacts.

Issues of Physician Choice

Question #1

(a) A patient wants you to be his physician. Can you decline if he refuses to disclose his HIV-status?

(b) An AIDS patient requires a routine procedure (such as a TAH-BSO, tonsilectomy, or bronchoscopy) which carries with it a risk of exposure to the health care provider. Can you, as his physician, refuse?

Answer

Whether a physician has a duty to treat a patient depends on whether a "doctor-patient" relationship has been established. Once a physician has initiated any type of "care" for a particular patient, a doctor-patient relationship is said to exist. This "care," however, usually does not include pre-employment physical exams or gratuitous advice ("curbside consults").⁴

What does the AMA have to say about the professional duty to treat HIV-positive patients? The current position of the AMA is as follows:

"It is unethical to deny treatment to HIV-infected individuals because they are HIV seropositive or because they are unwilling to undergo HIV testing, except in the instance where knowledge of the patient's HIV status is *vital* to the appropriate treatment of the patient. When a patient refuses to be tested after being informed of the physician's medical opinion, the physician may transfer the patient to a second physician who is willing to manage the patient's care in accordance with the patient's preferences about testing. (*italics added*).⁵

Thus physicians have an ethical duty to treat all HIV-positive patients. This current position of the AMA is a departure from their

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1980 Principles of Medical Ethics (Preamble section VI), which stated that: "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve..."⁶

This ethical duty, however, does not necessarily dictate a legal standard and a breach of professional ethics alone is not something for which a physician can be sued. On the other hand, although the AMA's advisories on ethical behavior are not law, the courts often look to these types of ethical standards to establish the requisite standard of care.

Suits against physicians may be based on the Federal Rehabilitation Act of 1973⁷ or the Americans With Disabilities Act of 1990 (ADA).⁸ Although these are federal statutes, many states, including Hawaii, have similar laws. Both federal and state laws protect handicapped individuals from discrimination unless that individual poses a "significant" risk to others and reasonable measures cannot be made to accommodate them. The Rehabilitation Act applies only to those programs that receive federal funding, while the ADA extends this protection to virtually all employers and public accommodations. HIV/AIDS patients fall under the protection of these acts, but because of the severity of the risk (death from AIDS), courts have sometimes found that AIDS patients can be considered a "significant" risk and thus excluded from protection.

Litigation results vary depending on the facts of the specific case. For instance, in Howe v. Hull, a 1994 case, a physician was found in violation of the ADA when he "referred" a patient away to another hospital across town reportedly because the latter was better equipped to handle that patient's particular condition. The court held that this transfer was pretextual and that the physician's refusal to treat was based on HIV discrimination.⁹ In contrast, in the 1993 case Toney v. U.S. Healthcare, a different federal court found a physician justified in his refusal to treat. The Toney court stated: "If others with the same handicap (HIV) do not suffer the discrimination, then the discrimination does not result solely by reason of the handicap".¹⁰ In other words, if not all HIV positive patients were refused treatment, then HIV could not have been the basis of the refusal.

In Hawaii, there has only been one case involving the "refusal to treat." In Doe v. Kahala Dental Group,¹¹ a dentist refused to treat a patient because of his refusal to disclose his HIV-status. The dentist informed the patient that based on the information requested, Kahala Dental Group might need to take different precautions as the proposed procedures involved exposure to his blood. The patient refused to provide the requested information and dental care was denied. The patient sued alleging handicap discrimination. The Hawaii Supreme Court agreed with Kahala Dental stating that "the prospective refusal of services was based, not upon appellant's having a handicap, but upon appellant's refusal to furnish information as to his physical condition." Thus, in Hawaii, inquiries about a patient's HIV-status are medically acceptable. Kahala Dental does not, however, stand for permissible refusal to treat a *known* HIV-positive patient.

Question 1(a) is the Kahala Dental case. The physician has yet to establish a doctor-patient relationship, so Hawaii case law suggests that he has no legal duty to the patient if the medical information regarding his HIV status is not forthcoming from the patient. Ethically, however, he is bound to serve as the patient's physician (because of the AMA standards...). Question 1(b) describes an established doctor-patient relationship and thus a duty to treat

imposed by the law. Since future application of the law is still unclear, at a minimum, a physician who decides to refuse to perform a requested procedure, must provide the patient with referral to another provider who will do the procedure and assume care of the patient else he will be liable for abandonment.

Issues of Consent

Informed consent is a prerequisite prior to any treatment or procedure. This section examines whether a physician's HIV-positive status constitutes a material risk that needs to be disclosed to a patient as part of proper informed consent. Also discussed are preemployment HIV screening, testing during pregnancy, and non-consensual HIV testing.

Question #2

A surgeon with AIDS is required by his employer hospital to disclose his HIV status to all of his patients prior to performing any procedures. Need he comply?

Answer

This situation is taken from an actual case in which the surgeon went along with the disclosure order and eventually suffered financial ruin (Behringer v. Medical Center at Princeton).¹² He subsequently filed a discrimination suit based on the ADA against the employer hospital. He lost the case because the court held that the severity of the risk, death from AIDS, necessitated the need for full disclosure as part of proper informed consent.¹³

Prior to 1990, there was no reported transmission of HIV from a health care provider to a patient. This changed when a Florida dentist, Dr David Acer, was found to have infected five of his patients. Public hysteria failed to produce legislation mandating HIV testing and disclosure for physicians. The AMA and the CDC, however, have made recommendations requiring both.

The AMA states: "[HIV-positive physicians] should either abstain from performing invasive procedures which pose an identifiable risk of transmission or *disclose their seropositive status* prior to performing a procedure and *proceed only if there is informed consent*."¹⁴ (Emphasis added)

The CDC requires that all health care providers adhere to strict universal precautions and suggests that an HIV-infected physician refrain from performing exposure prone procedures or seek counsel from a review panel. "If such panel feels that the infected health care provider be allowed to continue practicing, he should be *required to disclose his HIV-positivity* to all of his patients prior to performing any sort of invasive procedure on them thus obtaining *informed consent*".¹⁵ (Emphasis added)

Taken together, these directives from the AMA and the CDC and the case decision of Behringer stand for the following advice: The HIV-positive physician should refrain from performing any exposure-prone procedure. The only alternative is to inform the patient and obtain specific consent before proceeding.

Question #3

Can a hospital require an HIV screen as part of the application for staff privileges?

Answer

No. Mandatory HIV testing of physicians cannot be a condition for staff privileges, even for specialists who perform exposure-prone procedures. Even if screening were implemented, many unanswered questions would remain. Which physicians will need to be screened? At what intervals should screening be done? Who will pay for all the testing? These questions aside, mandatory testing of physicians could be considered an undue invasion of a constitutional right to privacy. As one AIDS expert has stated: "Screening without consent represents an invasion of human rights by undermining the person's autonomy and physical integrity... Required screening of health care professionals would indeed be ironic when programs for prisoners, immigrants, sex workers, and others at high risk have been already rejected."¹⁶

Question #4

You have sent your patient's blood to the lab to work up a fever of unknown origin. As an afterthought, you want to include an HIV screen. Can you?

Answer

Hawaii Revised Statute section 325-16 requires written consent from a patient prior to HIV testing. This informed consent is not the same as a general consent in that it must specifically state in writing that the consent given is for HIV testing. Exceptions to this rule include: (1) anatomical gifts; (2) research studies; (3) anonymous testing carried out at HIV test sites; (4) consent already obtained by a third party, e.g. an insurance carrier; (5) the patient is *unable to give consent* and his HIV status is necessary to make a diagnosis or determine a treatment plan; and (6) the patient is *unable to give consent* and there is reason to believe that the safety of a health care worker would be affected due to exposure to the patient's bodily fluids. Exceptions (5) and (6) are most relevant to the practicing physician. To trigger these exceptions, however, the patient must first be incapacitated and "unable to give consent."

Thus, in question 4 above, in order to include the HIV screen, you as a physician would first have to obtain written informed consent and give the pre-test counseling required by law. To add on the screen without the patient's specific consent would violate the law.

Question #5

Since AZT use during pregnancy decreases the possibility of infection of an unborn infant, can a pregnant woman be required to undergo mandatory testing for HIV?

Answer

No, or at least not yet. Even though lives may be saved by the prophylactic use of AZT in pregnancy, mandatory testing is generally held to violate the individual's right to privacy.

The proportion of women afflicted with HIV or AIDS continues to rise. In 1987, women represented only 4% of AIDS cases. Today, they make up nearly 20%.¹⁷ In 1994, approximately 8000 infants were born to HIV-infected mothers. Studies on antepartum AZT therapy have demonstrated a reduction of the 15-40% infant transmission rate.¹⁸ In addition to the reduction of infected infants, proponents of mandatory testing cite as a second benefit the increased caution physicians will exercise knowing that their patient is HIV-positive.

Whether the law will carve out an exception to the current privacy protection in the future remains to be seen. For now, CDC suggests that doctors counsel all pregnant women about the benefits of being tested for HIV. In a recent advisory, the AMA stated that all pregnant women should undergo mandatory HIV testing. By law, however, the states and the US government only require that all practitioners advise every pregnant woman of the value of testing for HIV and to ask each pregnant woman to consent to testing.

Issues of Confidentiality

Question #6

A dermatologist suspects that a patient's skin lesion may be associated with AIDS. He calls you, the primary care physician. Can you disclose to him the patient's HIV/AIDS status?

Answer

Yes. Physicians directly involved in a patient's care may disclose HIV status to one another, provided that the disclosure is pertinent to the patient's continuing care. H.R.S. 325-101 lists this as an exception to the strict confidentiality rule: "Release is made by the patient's health care provider to another health care provider for the purpose of continued care or treatment of the patient." Otherwise, the strict confidentiality rule states that: "The records of any person that indicate that a person has an HIV infection, ARC, or AIDS, which are held or maintained by any state agency, health care provider or facility, physician, laboratory, clinic, blood bank, third party payor, or any other agency, individual, or organization in the state shall be strictly confidential... (R)ecords shall be broadly construed to include all communication which identifies any individual who has HIV infection, ARC, or AIDS..."

Question #7

Your patient tests positive for HIV. Despite extensive counseling, he refuses to tell his wife. Moreover, he does not plan to take any precautions as she will become suspicious if he suddenly begins using condoms or abstaining from intercourse. Can you inform her?

Answer

One of the basic tenets of medicine is physician-patient confidentiality. The Hippocratic oath states that: "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about." This tenet of confidentiality has been modified somewhat, and is held to be absolute unless "they infringe in a material way upon the safety of another person or persons."¹⁹

The landmark case of Tarasoff v. Regents of the University of California²⁰ in 1976 led to this modification. In Tarasoff, the defendant psychologist was found negligent for failing to warn a young woman whom his patient had threatened to kill. The patient eventually did stab her to death. The psychologist's defense was that he believed the psychotherapist-patient privilege prevented him from breaching confidentiality. The California court held that a patient's right to strict confidentiality was limited by the third party's right to personal safety, and that confidentiality must yield

to disclosure when a named person was placed in danger.²¹ Note that in *Tarasoff*, the duty to warn applies only when the harm is *foreseeable* and threatens a *specific*, or *readily identifiable* person.

Where there is a specific HIV-confidentiality statute, adherence to the wording of that statute is important. In Hawaii, H.R.S. Section 325-101 specifically mandates strict confidentiality of any records pertaining to a patient's AIDS status and provides for disclosure to third parties *only* via the Department of Health.

Thus, in Question 7, the physician's first step is to attempt to convince his patient to disclose to his spouse his HIV status. If the patient refuses, the physician may then notify the Department of Health. The patient should be informed that the Department of Health will be notified and that such identification is proper. According to H.R.S. Section 325-101, the Department of Health will then assume the task of contact notification. (Some states handle notification by special spousal notification groups.) The Hawaii State Department of Health's policy is to notify all contacts at risk *without* disclosure of the identity of the HIV patient.²²

The relevant statute in Hawaii, H.R.S. Section 325-101(4), gives the physician the *option* to report to the Department of Health the name of "the sexual or needle sharing contact of an HIV seropositive patient," in order for the contact to be notified. The statute goes on to state that: "[a]ny determination by a physician to disclose or withhold disclosure of an index patient's sexual contacts to the department of health. . . shall not be subject to penalties..."²³ Thus the statute seems to protect a physician from suit if he chooses not to inform the Department of Health of potential at-risk parties. The statute does not specifically give a physician the authority to directly notify the patient's spouse or other contacts that may be at risk.

Question #8

A patient is suing you for allowing his HIV-positivity to become known to the public. He states that someone in the billing department of his medical insurance carrier recognized his name and diagnosis. Are you liable?

Answer

What happens when a physician makes an insurance claim for reimbursement for services rendered to an HIV/AIDS patient? Is this a breach of confidentiality? According to Hawaii Revised Statute Section 325-101(a)(9), release of HIV/AIDS information to the patient's insurer is an exception to the otherwise absolute confidentiality rule, but "release shall not be made if, after being informed that a claim will be made to an insurer, the patient is afforded the opportunity to make the reimbursement directly and actually makes the reimbursement." One should therefore inform the patient that the diagnosis will appear in his insurance claim form and offer the patient the chance to make direct payment if he or she chooses not to have the diagnosis made known to the health insurer.

Question #9

You are contacted by the principal of your local elementary school. He is inquiring about the HIV status of one of his students who is rumored to have AIDS. He is worried about the safety of the other students. As the child's physician, can you disclose this information?

Answer

Hawaii's HIV-confidentiality statute forbids such disclosure. The American Academy of Pediatrics, the National Education Association, and the CDC have all advocated that children with control over their bodily functions should be allowed to attend school without interruption.²⁴ Social contacts in school settings are not considered "at risk." However, the risk status can change over the course of a patient's illness. If at some point in time the child begins to: (1) lack control of bodily secretions or excretions; (2) become prone to biting, spitting, or vomiting; or (3) develop open skin lesions, safeguards for the benefit of other students may then need to be implemented.

Question #10

You discover that one of your HIV-positive patients is working as an operating room technician. The patient refuses to inform his employer because he fears losing his job. Can you inform his employer?

Answer

Breach of this patient's confidentiality in order to protect the surgical patients at the local hospital can be done only via the Department of Health. According to H.R.S. Section 325-101, the physician can release information to the Department of Health in order to inform contacts that the physician believes are at risk. This, of course, follows counseling and recommendation to the index patient to disclose and the patient's continued unwillingness to inform the contacts himself or consent to disclosure by the physician. Whether the employer hospital will be notified is left to the discretion of the Department of Health.

References

1. Centers for Disease Control, *Morbidity and Mortality Weekly Report*, Nov. 18, 1994, Vol. 43, No. 45.
2. Pierce, Fisher, and Rabin. An Overview and Introduction to HIV Infection. *Courts, Health Science and the Law*. Summer, 1991, Vol. 2, No. 1.
3. American College of Physicians Ethics Manual, 3rd Edition. Quoting CDC MMWR. 1989; 38:S-6.
4. Snyder. "The Current Status of the Physician-Patient Relationship." *Hospital Physician*, Sept., 1995, page 44.
5. AMA Code of Medical Ethics 1996-1997 Edition.
6. *Id.*
7. Rehabilitation Act of 1973, 29 U.S.C. sect 794.
8. Americans With Disabilities Act of 1990, 42 U.S.C. sect 12101.
9. *Howe v. Hull*. 87 F. Supp 72 (1994).
10. *Toney v. U.S. Healthcare*. 838 F. Supp. 201(1993).
11. *Doe v. Kahala Dental Group*. 72 Haw. 150, 808 P.2d 1276.
12. *Behringer v. Medical Center at Princeton*, 249 N.J. Super. 597, 592 A.2d 1251.
13. *Id.*
14. American Medical Association, Statement of HIV-Infected Physicians (Jan. 17, 1991).
15. Centers for Disease Control, Recommendations for Preventing Transmission of HIV and HBV to Patients During Exposure-Prone Procedures, 40 *Morbidity and Mortality Weekly Report* 1 (July 12, 1991).
16. Gostin. The HIV-Infected Health Care Professional. *Archives of Internal Medicine*, Vol. 151, April, 1991.
17. Smith H., The Deadly Politics of AIDS, *Wall Street Journal*, Oct. 25, 1995.
18. Dickover, Ruth et al, Identification of Levels of Maternal HIV-1 RNA Associated With Risk of Perinatal Transmission, *JAMA*, Feb. 28, 1996, Vol. 275, No 8.
19. American Medical Association, Current Opinions of the Council on Ethics and Judicial Affairs, Chicago, AMA, January 1987.
20. *Tarasoff v. Regents of the University of California*, 118 Cal Rptr. 129, 529 P.2d 553 (1974).
21. Friedland, HIV Confidentiality and the Right to Warn - The Health Care Provider's Dilemma, 80 *Mass. L. Rev.* 3, Mar 1995.
22. Telephone Interview with Dr. Richard Vogt, State Epidemiologist, Hawaii State Department of Health.
23. Haw. Rev. Stat. Sect. 325-101(a)(4) (1993).
24. American College of Physicians, The Acquired Immunodeficiency Syndrome and Infection With the Human Immunodeficiency Virus. Health and Public Policy Committee. *Annals of Internal Medicine*, 1988;108:460-469.